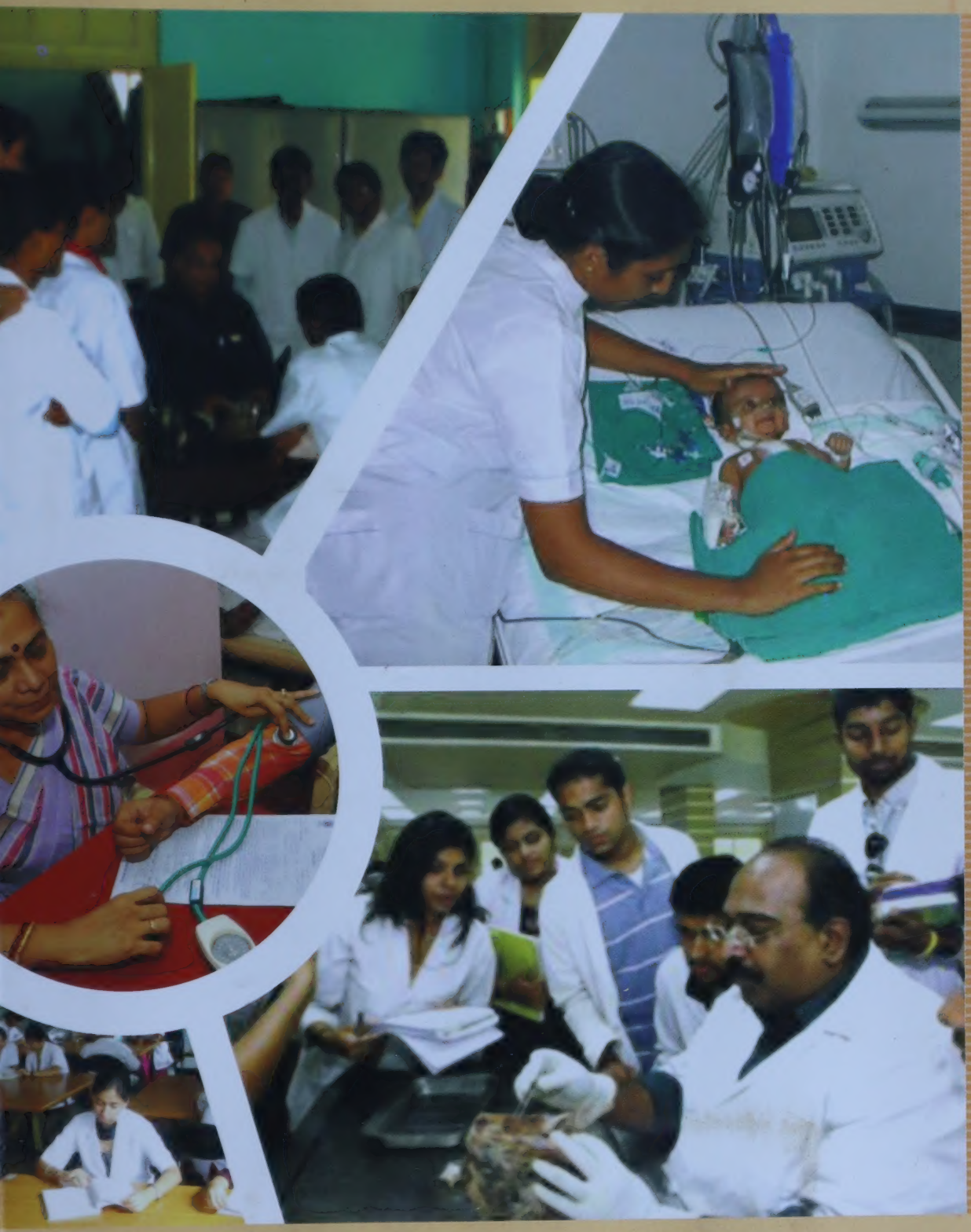
# STATUS REPORT



By

## STUDY GROUP ON DELIVERY OF HEALTH SERVICES


**Karnataka Jnana Aayoga**

(Karnataka Knowledge Commission)

**Government of Karnataka**

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Room No. 219, II Floor, Vidhana Soudha,
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**Status Report By Study Group on Delivery of Health Services**



Published by
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# FOREWORD

The Working Group on the Health Sector set up by the Karnataka Jnana Aayoga divided its task into three sub-sectors of medical education, delivery of health services, and traditional medicine. The present report by the Study Group on the delivery of health services deals with the core segment of the health sector, where medicine directly interacts with the society. While highlighting the achievements of Karnataka in the health sector, the Study Group has pointed out the pitfalls and deficiencies which call for corrective action.

The Study Group notes that Karnataka has performed better than average on the achievement of national health indicators and have made significant improvements in key health indicators between the National Family Health Surveys (NFHS) 1 (1992) and 3 (2005). The reduction of fertility to replacement level, reductions in infant and maternal mortality, increase in institutional delivery are examples of improvements between NFHS 1, and 3, but the Study Group notes that "a lot remains to be done" as several states in the South have out-performed Karnataka in terms of health indicators. This is conspicuous in indicators such as infant mortality, performance in vaccination, and prevalence of anemia. There is also evidence that Karnataka is undergoing epidemiological transition as the life time risk of dying from ischemic heart disease, chronic lung disease and cancer is higher in Karnataka than the national average.

Apart from providing a review of the current status, the Study Group notes that the Government of Karnataka have already implemented 60-70% of the recommendations of its Task Force for Health services and reconstituted a High Power Committee to implement the remaining ones, which include several major recommendations such as the reorganization of the Health Department, setting up a public health cadre, and several others. In making an eloquent plea for promoting good governance in health care management, the Report has listed a number of important steps for immediate action such as the introduction of a Health management information system (HMIS), e-procurement of drugs, and the review of staff transfer policies. Human resource development and management, and health care financing are other important areas which have received the special attention of the Study Group.

The expert members of the Study Group and the Resource persons who assisted the Group are pleased to submit this Report for the consideration of the Government of Karnataka.

Date: November 18, 2010

**M S VALIATHAN**

Chairman, Working Group on Health Sector, Karnataka Jnana Aayoga

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## Contents

## INTRODUCTION

Under the Karnataka Jnana Aayoga, a Study Group on Delivery of Health Services was set up to evaluate the health sector status and to come out with the recommendations for strengthening the health sector areas. At the meeting, the members of the study group agreed to write an Interim report and evolve a set of recommendations for improving delivery of health services in Karnataka.

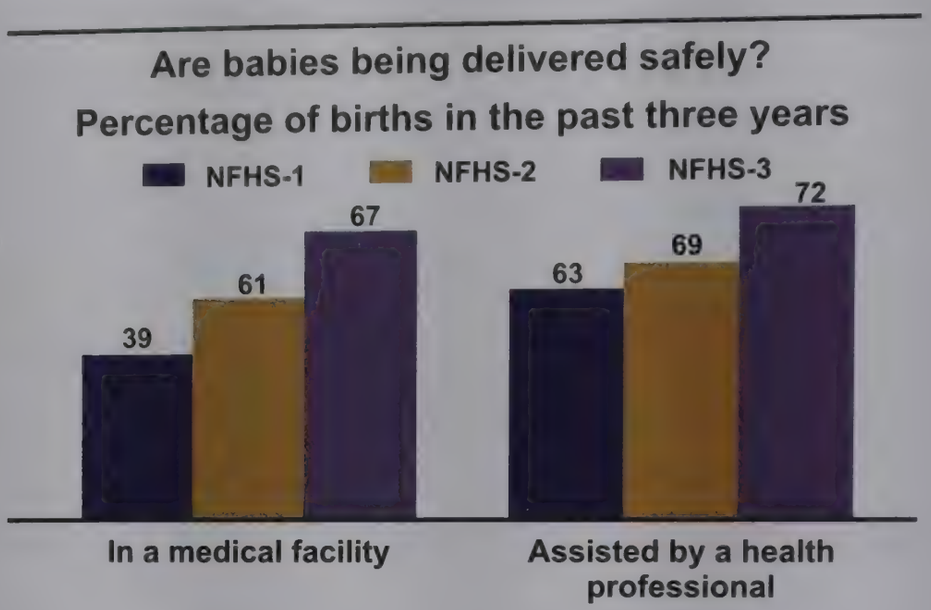
### Current Health Status

Karnataka has emerged as one of the states that is performing better than average on achievement of health indicators (Karnataka Health Task Force Report; xiii). The National Family Health Survey (NFHS) data indicates that there have been significant improvements in key health indicators between NFHS 1 (1992) to NFHS 3 (2005).

Fertility levels have reduced substantially and have, since NFHS 2 (1999), been at replacement levels. A woman in Karnataka will have 2.1 children in her lifetime, with a slight rural-urban differential. Karnataka is only one of ten states in India to have achieved replacement level fertility. This could be attributed to increasing contraceptive use: the number of women using any method of contraception has been steadily rising from 49% in NFHS 1 to 58% in NFHS 2 and to 64% in NFHS 3 (Karnataka State Report; NFHS 3), as compared to a national average of 56%.

Karnataka has performed relatively well with regard to maternal health, although, our neighbouring states have fared better on several parameters. 89% of women who gave birth in the five years preceding the NFHS 3 survey had received ante-natal care from a health professional. This compares to 96% in Tamil Nadu and 85% in Andhra Pradesh, while the India average is 52%.

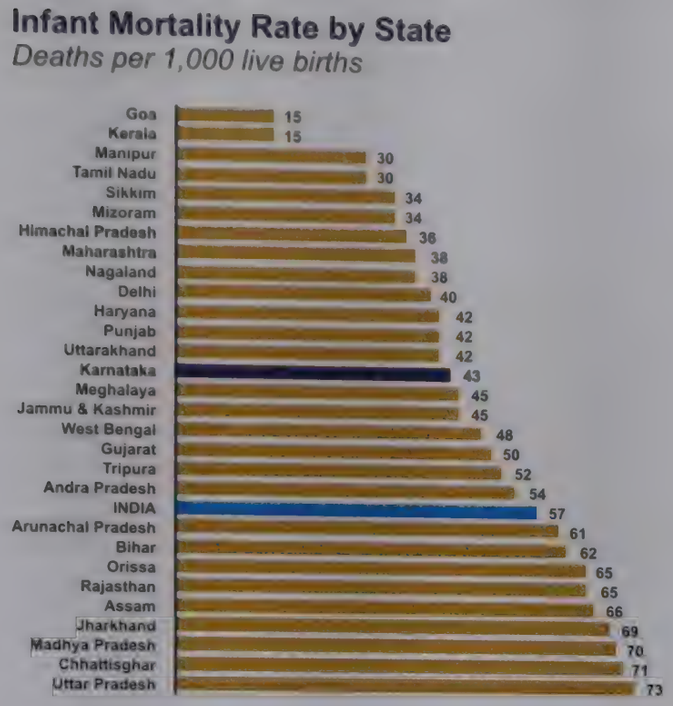
About two thirds of all births in Karnataka take place in an institution. This percentage has also been steadily rising, and the state is ranked fifth in the country for this indicator.




Source: NFHS 3 Karnataka State Report

While this is good news, it is a matter of concern that one in three deliveries in the state still takes place at home. Safe deliveries are a key strategy for reducing both maternal and child mortality, and need to be ensured for all women, both rural and urban.

While infant mortality has been declining in Karnataka, from 65 per 1,000 live births recorded in NHFS 1 to 43 per 1,000 live births in NFHS 3, a lot remains to be done.

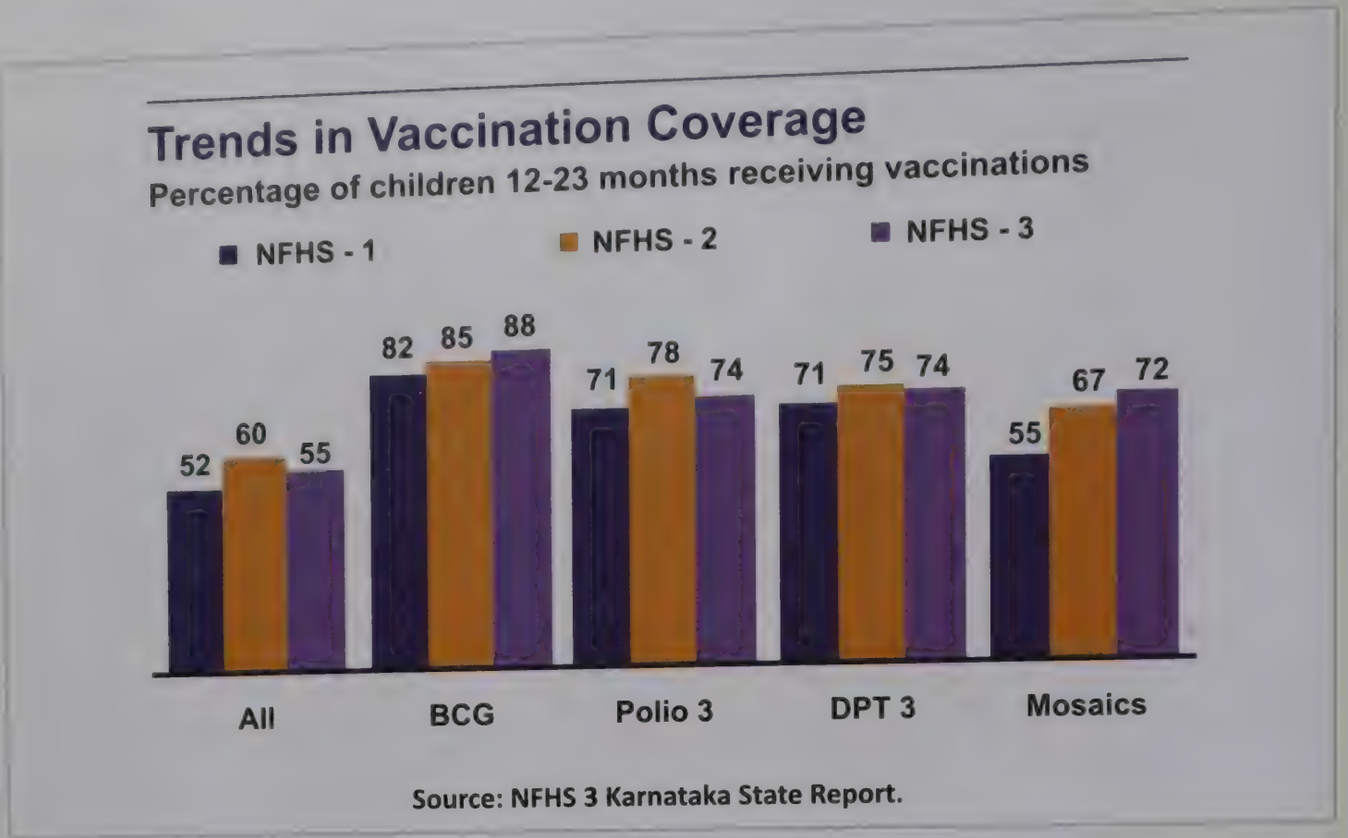



*Infant mortality is lower in Karnataka than in the nation as a whole; nonetheless, one in 28 children in the state still dies before his/her first birthday.*

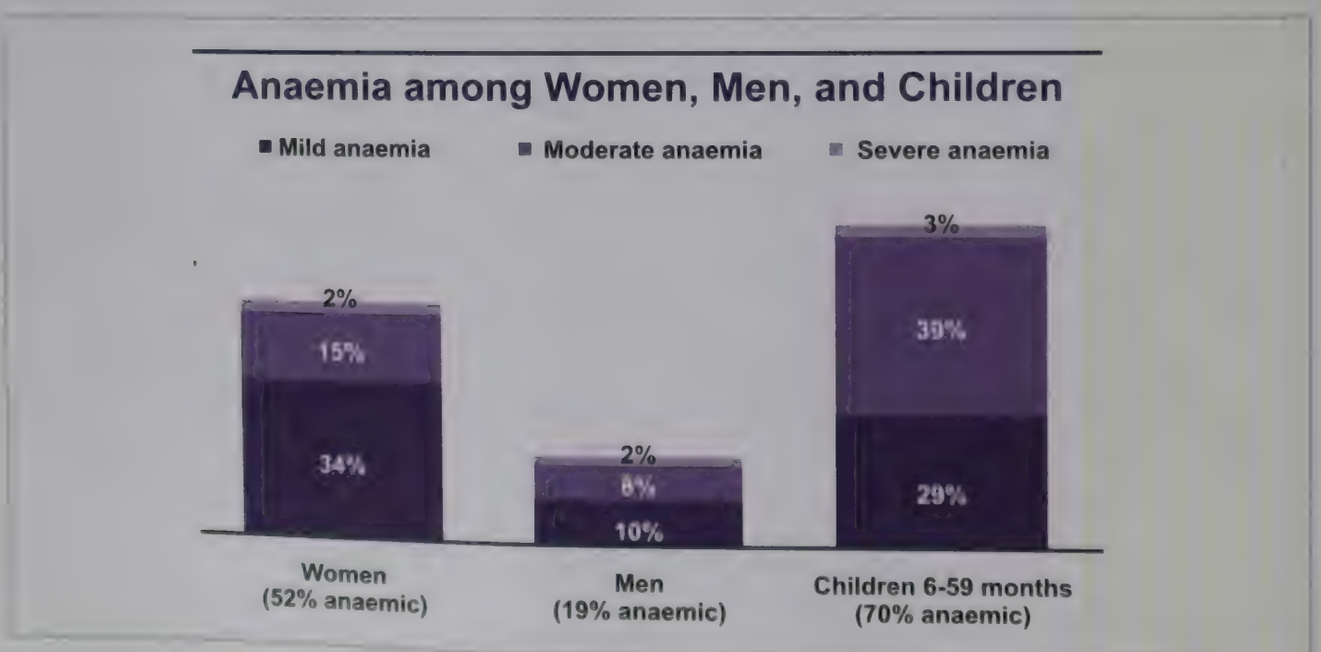
Source: NFHS 3 Karnataka State Report.

As the figure shows, infant mortality in Karnataka is still unacceptably high, and trails behind other southern states such as Kerala and Tamil Nadu. There is also a significant rural-urban differential, with 28% more deaths in rural areas.

Karnataka's performance on vaccination has been disappointing, with only 55% of children between 12-23 months being fully vaccinated. This is actually a reduction from the 60% coverage recorded in NFHS 2. Reducing infant and child mortality due to preventable causes through full vaccination is a crucial intervention. Coverage of BCG and polio vaccine is relatively better at 88% and 74% respectively.




Anaemia among men, women and children continues to be high, reflecting poor nutritional status. The survey also found that, while wasting and underweight in children has reduced since NFHS 2, stunting in children (low height for age) has remained stagnant, and is a matter of concern.



At the same time, the state is well into an epidemiological transition, and non-communicable diseases are becoming more of a challenge than communicable diseases, and the health system has to be able adopt a two-pronged approach towards an effective response. Research undertaken by the Centre for Global Health Research (CGHR, University of Toronto) indicates that among men aged 30-69 years, the lifetime risk of dying of ischemic heart disease is 7.1% (99% CI 6.2-8.0) as compared to a national average 6.3%. Similarly, men in Karnataka have a much higher risk of dying of both chronic lung disease and cancer than the national average. Women face a high risk of dying of cancer.

| Cause of Death | Risk of Dying Karnataka | 99% CI | Risk of Dying All India | 99% CI |
|---|---|---|---|---|
| **Men aged 30-69 years** | | | | |
| Ischemic Heart Disease | 7.1 | 6.2-8.0 | 6.3 | 6.1-6.5 |
| Stroke | 2.9 | 2.3-3.5 | 2.7 | 2.6-2.9 |
| Chronic Lung Disease | 5.0 | 4.2-5.8 | 3.7 | 3.5-3.9 |
| Cancer | 3.5 | 2.8-4.1 | 2.8 | 2.7-2.9 |
| **Women aged 30-69 years** | | | | |
| Ischemic Heart Disease | 3.3 | 2.7-4.0 | 3.2 | 3.0-3.4 |
| Stroke | 2.0 | 1.4-2.5 | 2.4 | 2.2-2.5 |
| Cancer | 3.7 | 3.0-4.4 | 3.2 | 3.1-3.4 |

## Health Sector Issues

The report of the Karnataka Health Task Force (2001) identified some of the key issues facing the health sector in Karnataka. Several of the issues identified at the time have been addressed by the government, including enhancing allocations to the health sector, increasing partnerships with the private sector and strengthening implementation, particularly under the National Rural Health Mission. However, there continue to be issues that need to receive attention, including:

- Weak Institutional Capacity

  Implementation capacity continues to require strengthening, and effective performance is impeded by poor management and accountability at various levels within the system. An important issue to address is the need for a trained cadre of personnel who have a good understanding of public health priorities and strategies for addressing them. Many of the public health measures needed to improve Karnataka's performance on key indicators would be reinforced by having a public health cadre. Government of Karnataka has been proactive in trying to address this issue by commissioning an Organisational Development Study (2008) which provided insights into the causes and impacts of poor performance at various levels of the health system. Based on this, the government is planning a series of capacity development programs.

- Public, Voluntary and Private Sector Partnership

  Karnataka has a vibrant private sector in health in both the non-profit and for profit sectors. Many areas exist for fruitful collaboration

between public and private (NGO and for profit) actors in the health sector. Many examples exist in Karnataka of collaboration with the private sector which have served as models across the country, including contracting out of primary health centres in difficult areas, implementation of HIV prevention interventions and managing health insurance schemes. However, there are many more opportunities for expanding this collaboration that will serve the government's objective of increasing access to quality health care and improving performance of key health indicators. The state has already made important progress on this front by passing the Karnataka Private Health Establishment Act, one of the first states to do so in the country, and this will enable the state to build on its engagement with the private sector.

- Inequity in Access to Services

There are several issues relating to inequity in access to quality health services, which have a significant impact on health outcomes, including: (i) unacceptably high levels of maternal mortality, particularly in rural areas; (ii) regional imbalances, with certain districts and blocks within districts having significantly poorer health outcomes as compared to the rest of the state; and (iii) rural-urban differentials in health outcomes.

- Unfinished Agenda and New Challenges

There is still a large "unfinished agenda" related to women and children's health, malnutrition, and control of communicable disease. Despite the significant progress made on many of these fronts, there is

much that needs focused attention. At the same time, the system has to gear up to address the growing burden of non-communicable disease. The leading causes of death from NCDs are heart disease, diabetes and cancers. The epidemiological transition will speed up as the population ages and will require a health care system that can deliver high quality outpatient and inpatient services at an affordable cost. In addition, the economic and social impact of morbidity and mortality during the most productive years of a person's life would be profound. Addressing the agenda of NCDs will require new types of services and new approaches, for which there are currently no large-scale models in India. For some of these conditions, highly cost-effective interventions in both primary and secondary prevention have been developed – for example, for reducing cardiovascular disease through improvements in diet, exercise, and smoking, plus control of hypertension and blood lipids. Yet there are few policies or programs in place in Karnataka to support the implementation of these interventions.

## Karnataka State Health Systems Resource Center

The National Rural Health Mission (NRHM) requires the establishment of State Health Systems Resource Centers (SHSRCs) in all states. Karnataka established a SHSRC in 2009, and it is now staffed and functional. The goal of the NRHM has been to significantly impact health outcomes for the people. Recognizing that health systems at the national and state levels need to be strengthened to carry out the ambitious program of expansion and reform envisaged under the NRHM, provision was made for the setting up of a body that could undertake the necessary policy development and capacity building required to effectively implement

the NRHM. This is the SHSRC. Some states, such as Chattisgarh, have already made substantial progress in operationalising their SHSRCs, and the positive impact of that can be observed in some of the policy changes and improvements on the ground taking place.

Government of Karnataka (GoK) has demonstrated its commitment to enhancing the performance of the health sector and the Karnataka Knowledge Commission is making a commendable effort towards identifying steps that need to be taken on a priority basis in order to address the key constraints to Karnataka reaching the next level. **Organizational development** of the Health Department, and **capacity building** at both the state and district levels have been identified as urgent needs if the state is to move forward and provide its citizens the same level of good health as has been achieved by neighbouring states. It is important that the SHSRC as well as the State Institute of Health and Family Welfare – an institution that has been functioning for many decades – be closely involved in the development and implementation of this capacity building program.

There are some major concerns and cross cutting themes which are covered in the report that can affect health aspects and some sectors of health care. The Study Group has come out with a large number of recommendations given under each section to improve health of the people and strengthen health care services in Karnataka, with special focus on public health and its delivery of health services.

## IMPLEMENTATION OF THE TASK FORCE

When studying the issues relating to health services, it is apparent that the key factor that influences the efficiency of these services and ensures the social accountability of the system is the issue of governance. It is apparent that professional skills, financial allocations and departmental infrastructure, can contribute to performance only up to a point. The core issue, however, remains the motivation and commitment of the staff. There is need to nurture the young health professional and other allied health workers, supervising and facilitating them. There is also the need to institutionalise discipline tempered with morale building, peak performance and accountability to the public, together with the involvement of the people in attaining and maintaining their own health. The recommendations on restructuring of the health services have been made keeping these essential parameters in view.

As an effective measure for implementation of task force recommendations and for monitoring implementation and generally to further the objectives of rapid improvement of the health services, the early constitution of the Commission on Health recommended herein is urged.

About 60-70% of the recommendations have already been implemented, however the hard core issues like Public Health Cadre have not yet been implemented. We suggest that the High Power Committee which has been reconstituted should immediately meet and see that the rest of the recommendations are implemented.

Once these recommendations are implemented, the health services in the State will achieve both professional competence and efficiency of a

high order, with equity, so as to serve the people of the State to their full expectations, contributing to the enhancement of their quality of life.

**The important recommendations of the Task Force which need to be implemented are:**

- Reorganisation of the Health department. Create Public Health Cadre. Introduce separate cadres titled Medical Director (under district health cadre) and Director of Public Health (under Public Health cadre).

- Creating District health Cadre to address the problem of vacancies in the backward districts of Karnataka - The doctors will be selected for the particular district and they will be not transferable till they become state cadre.

- Strengthening the Health Education (Promotion) Unit for effective Behavioural Change Communication (BCC).

- Management of Non-communicable diseases - creating a post of program officer at District level for managing CVD, Diabetes, Cancer, etc.

- Establish separate stream of career paths for Specialists, Hospital Management personnel and Public Health Professionals from amongst the Medical fraternity.

## 3 GOOD GOVERNANCE FOR EFFECTIVE HEALTH MANAGEMENT SYSTEM

As outlined by the United Nations, Good Governance stands where persons and departments charged with authority are accountable, effective and efficient, participatory, transparent, responsive, consensus - oriented and equitable; and in short anti-corruption. Effective governance relies on the interrelation of all the checks and balances within an organization. Stakeholders must be empowered to participate in meaningful ways in decision-making processes i.e., Information Communication and Technology (ICT) applications. To fulfil the demands of good governance on a continuous basis, a Think Tank needs to be established which shall plan health management with strategic perspective on a roll on plan basis.

**Good Governance demands the following to be put in place in Health Department:**

1. Clearly articulate and implement policies and procedures in respect of the following without external interference.

   - Drug procurement & distribution policy.
   - Equipment procurement, maintenance and retro-fitment.
   - Recruitment policy including lateral recruitment.
   - Transfers policy.
   - Promotion policy based on objective performance appraisal.
   - Administering discipline to ensure accountability at all levels.

2. Prescribe a relevant code of ethical behaviour and clearly spell out consequences of violation of this code with appropriate strengthening of disciplinary procedures under Karnataka Medical Council.

3. A review system at all levels, which promotes the ethical code prescribed for the organization and the medical fraternity. This shall also address crucial issues such as:

   - Sex selective abortion
   - Unethical drug trials
   - Code of conduct for drugs controllers, licensing of drugs and withdrawal of drugs
   - Reforms required in Karnataka Medical Council

4. A sound independent and internal control framework and effective external audit.

5. Transparent disclosure and effective communication by adoption of e-Governance with a view to strengthen the existing system.

6. Systems that ensure effective measurement and establish accountability quickly.

7. Regularly gather the voice of the stakeholders and address their concerns.

8. A robust Management Information System (MIS) which shall cover the information in respect of personnel of health department,

decision support system for monitoring and supervising health management programmes and facilitate the RTI and Transparency Act implementation to full extent.

9. Strengthening and governing of private clinical establishment for better health delivery.

**Steps for the immediate action are:**

- Introduce Health management information system (HMIS) through electronicmedium across all departments and activities under the department of health. This shall support speedier decision at all levels in all matters of administration covering management of Manpower, Hospitals, PHCs, Sub centres, financial planning and material resources. An Enterprise Resource Package available in market may be considered after due examination.

- Introduce e-procurement of drugs and equipment to eliminate delays and render them transparent to all concerned stakeholders.

- Establish roles and responsibilities of all positions from the Directorate level up to the PHC level. This shall list the deliverables of each position and the associated qualification, experience, knowledge and the behaviour traits necessary to fulfil the role.

- Review service rules to render them suitable to the needs of the time and better enforceable. Indoctrinate all personnel of the department on service rules at induction level as well as through periodic reinforcement.

- Develop health department operational manual keeping in view the needs of the stakeholders. Give wide publicity of department manual to all stakeholders through electronic medium as well as print medium for easy access.

- Give wide publicity to consequences of breach of service rules internally.

- Transfer policies to be reviewed and redrafted to meet the current and future needs of the department. This shall include the system of counselling to ensure matching of the individual medical personnel requirement with that of the vacancies available. The transfer policy shall ensure that each vacancy is filled by a person who meets the job description specified for the post in terms of qualifications, specialisations, length of service and experience in the specific discipline. The transfers shall be administered with the support of electronic system which shall avoid mismatch of vacancy and the person available for transfer. The policy shall be given wide publicity through internet to educate all stake holders including people representatives to support its implementation both in letter and spirit Transfer policies to be implemented without any deviation and external influence.

- Gather opinions of the stakeholders periodically and give feedback to them on the actions taken.

- Evaluate performance of each department through internal assessment as well as external audit to ascertain efficiency and effectiveness of the health management practices adopted by them.

- Establish convergence amongst departments that determine health viz. Nutrition, Education, Sanitation and Health delivery system through a review and monitoring mechanism at a level appropriate to drive cohesion amongst these elements to achieve the overall objectives of health system. The departments to be addressed under this would be Health & Family Welfare, Women & Child Welfare, Rural Development, Education & Panchayat Raj.

- Introduce GIS for disease surveillance.

The goal of Human Resource Development (HRD) policy is to ensure availability of suitably qualified, appropriately skilled and motivated human resources for health at appropriate geographic level of pre-defined disciplines. Improved decisions require up-to-date and detailed information about three components of human resource for health: (a) The workforce (b) The work performed (c) The work settings. Strong leadership and management skills are crucial to finding solutions to the human resource crisis in health.

Way of looking at Human Resource Development can be from its scope in terms of strategic and tactical perspective. Under Strategic perspective – Organization Planning, Manpower Planning and Career Planning while under Tactical perspective – organization's and individual performances set the scope of annual activities under HRD.

**a. HRD and its relevance to Medical Professionals:**

Many medical professionals perceive HRD as the responsibility of Personnel department located at the head quarters and this results in shifting of responsibilities to wrong people. The responsibility of the professional in the field is much more towards the manpower placed in his hands and ultimately the individual himself has to take interest in his own development. The HRD department can function mainly as a facilitating department and support the organization in developing the HR policies, HRD Instruments and processes and facilitate course ware (instruction manuals) development.

**Sub systems of HRD :**

The major sub systems that most of the HRD departments adopt to fulfil their obligations towards developing organization and the people are:

i. Organization planning and structuring, Manpower planning

ii. Role analysis and development

iii. Attitude survey (Organizational climate survey)

iv. Induction

v. Performance (work) planning, Analysis and review

vi. Performance counseling

vii. Training and Education

viii. Potential Appraisal

ix. Team Building

x. Career planning and development

xi. Succession planning

xii. Job rotation (Transfers)

xiii. Professional Networks – Learning Networks

xiv. Mentorship

xv. Stress Audit and Management

**The immediate actions recommended are:**

- Establish Human Resource Development Department within the broad frame work of Administrative Office at the Health & Family Welfare Dept.

- Carry out perspective planning for the Human Resource required to meet current and future demands placing special emphasis on Specialists, Nurses and Pharmacists required to render effective health care.

- Establish role clarity of all individual personnel, which eliminates duplication of roles and drives accountability.

- Introduce systematic Induction programme.

- Develop goal based open performance appraisal system involving self-appraisal, superior appraisal and review appraisal with dialogue between the subordinate and superior.

- Set up a system of periodic training including management training based on the immediate and long term deliverables of the health department, performance gaps in the individuals and growth ladder of the individuals' careers. This shall aim to address the skill levels required at different rungs of the organisation ladder. The training shall aim at certifying medical personnel for the different roles that they need to play as members of community health practitioners or Hospital management personnel. To facilitate this, all training establishments such as SIHFW, District Training Centres and the

HRD cell shall function in a coordinated way and supplement each other's activity ensuring elimination of duplication.

- The medical education shall respond to the emerging and current needs of the health services. To fulfil its obligation, a shorter Medical Education programme titled B.R.M.S of three and a half years duration with one year internship needs to be introduced. This will address the endemic shortfall of personnel of MBBS qualification at PHCs.

- Adopt e-HRM software package for administering all transfers. This shall ensure that all posts are filled only with people of prescribed qualification, experience and skill levels.

- Establish communication programme for Health Workers through suitable media.

## APPENDIX TO HRD & HRM

**a. Purpose of HRD office:**

i. To address the terms and conditions of employment for all staff.

ii. To establish and maintain a fair and equitable compensation system.

iii. To promote performance planning and review as a joint process between supervisors and employees.

iv. To develop training strategy directly linked to the goals of the organization.

v. To develop resources for meeting the future staffing needs of the organization.

vi. To maintain up-to-date employee data systems and personnel files.

vii. To assist in developing a professionally stimulating, stable and supportive working environment.

viii. To define and support practices which foster trust and respect between all levels of individuals in the organization.

- **HRM Staff Position Descriptions:**

The following position descriptions can provide guidance on developing the roles and responsibilities for staffing an HRM office.

i. Asst. Director - HRM - Overall responsibility for HRM activities and directly supervise transfers, promotions and disciplinary proceedings adhering to the prescribed policies. He shall report to commissioner of H&FW.

ii. Recruitment Officer

iii. Benefits Manager to oversee compensation mgt, rewards and incentives as prescribed by the policies.

iv. Training Manager

v. Personnel Assistant

**b. Induction:**

The Induction serves to introduce people to the rules and regulations of the workday and also other staff members. It also serves the essential requirement of acculturation of the individual to the health department and his role in the larger context of meeting the objectives of health governance.

i. Prepare induction packet or personnel manual.

ii. Make sure the new staff member has a place to work and the necessary supplies.

iii. Schedule necessary in-house meetings to link employee with other staff relevant to their job.

iv. Clearly explain the mission, goals and objectives of the program.

v. Explain the structure of the organization and the lines of authority.

vi. Provide any training necessary.

vii. Arrange a trip, if necessary, so that all off-site staff have opportunity to be included.

viii. Set clear performance objectives and tasks for the first 3 months of work.

**c. Performance Appraisal (Work, Planning and Review) :**

With careful planning and implementation, a Performance Planning and Review (PP&R) system provides the organization with :

i. Systematic Performance Planning

ii. Systematic Performance Review

iii. Objective Information : PP&R process will guide management decisions on salary and merit awards, promotions, transfers, work assignments and staff development needs.

The Performance Planning and Review process is a collaborative effort between two people. The major steps in the process are as follows:

i. Work Planning : Job Objectives and activities for the future course

ii. Performance Review : Performance Objectives and Performance Standards

iii. Performance Planning : Performance standards and goals (quantity, quality, and timeliness), Training and resource needs.

**A PP&R system requires that department has a standard form to be used as applicable to different levels of staff. The form shall be used to document the performance planning and review meetings and should have standard information and must be developed on the basis of needs of the department and the ability to implement objectively.**

**d. Training and Education :**

i. Linking Training and Education of personnel to the department goals and individual career growth objectives is necessary.

ii. The next step is developing the necessary curriculum and trained / experienced faculty to teach.

iii. Involving professionals' from the field and supervisors with back up support of course-ware and training methodology.

iv. Providing pedagogic skills to all professionals and supervisors since they have to be involved in delivering the training content to the participants.

v. Attention to be paid to the evaluation of effectiveness of training.

**Goals of Training Plan:**

Prioritise goals, training activities and the employee target groups, plan for resources needed to support the career development needs of employees.

**Process:**

i. Finalise the goals and rank in priority order.

ii. Assess the knowledge, skills and abilities of the existing staff.

iii. Develop a needs assessment process and train according to the needs of staff.

iv. Develop staff capacity to meet the department goals and accordingly develop a training plan.

v. Assessment of necessary resources and revenues.

**Training cost:**

Cost may include - Contracted and external trainers, Honoraria for resource persons, training course ware development, food / lodging, transportation for participants and resource persons, audio visual aids and miscellaneous.

## Current status of health financing in India:

There are four traditional sources of financing health care:

i. From government taxes

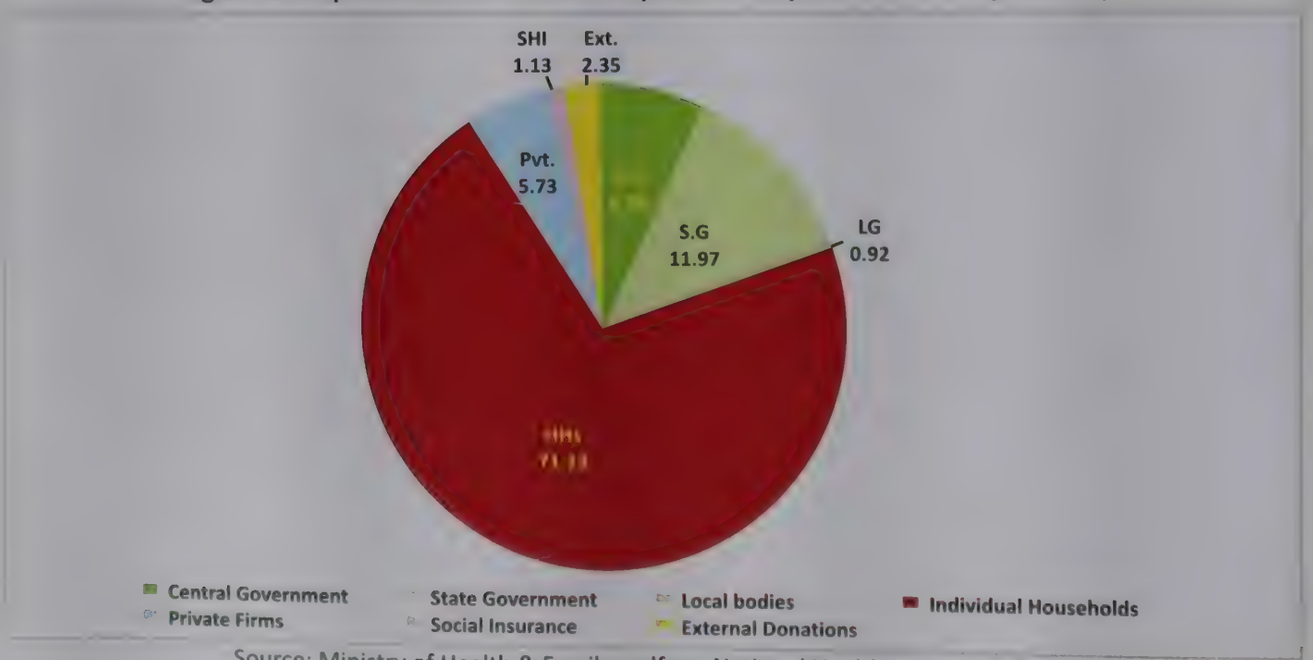
ii. From individual households through out-of-pocket (OOP) payments at the time of illness

iii. From external donors

iv. From the profits of private companies

In India, unfortunately, individual households bear the major burden of financing health care. The National Health Accounts (2004-05) estimates that 71.1% of the health care costs are borne by households. On the other hand, government (local, state and central) expenditure only accounts for 19.7% of total health expenditure.[1]

**Figure 1: Proportion of total health expenditure by sources: India (2004-05)**




Source: Ministry of Health & Family welfare. National Health Accounts 2009.

[1] Ministry of Health & Family welfare. National Health Accounts: India (2004-05) Government of India. 2009.

India has the dubious reputation of being a country with the highest OOP payments. One main reason for this is the low spending by the government. Currently, the entire government funding accounts for only 0.84% of the GDP. And most of this amount is on salaries. Thus most of the government health services lack medicines, necessary equipment and adequate personnel.

Consequently, patients shift from the government to the private health services and have to pay at the point of service. This has three effects: a) it reduces access to health care, especially for the poor and vulnerable b) it impoverishes some of those who use the health services; and c) it is inequitable – those who are poor face the highest burden of payment. Evidence from NSSO 60th round[2] suggests that about 6% of the patients do not seek care because of financial reasons. In another study, 24% of hospitalised patients were forced to borrow or sell their assets to meet the hospital expenses. And finally about 2 – 3% of Indians fall below the poverty line every year because of medical costs.

To protect the households from catastrophic expenditure, the government of India has introduced various pre-payment mechanisms like health insurance. The Ministry of Finance has introduced the Universal Health Insurance Scheme (UHIS); the Ministry of Health provides subsidies under the National Rural Health Mission (NRHM) for any state introducing community health insurance and finally the Ministry of Labour has introduced the Rashtriya Swasthya Bima Yojana (RSBY). Other than this, there are health insurance schemes by the Ministry of Handlooms; by the

[2] National Sample Survey Organisation. Morbidity, health care and conditions of the aged. GoI 2006.

Employees' State Insurance Corporation (ESIC) and also by the Defence Ministry.

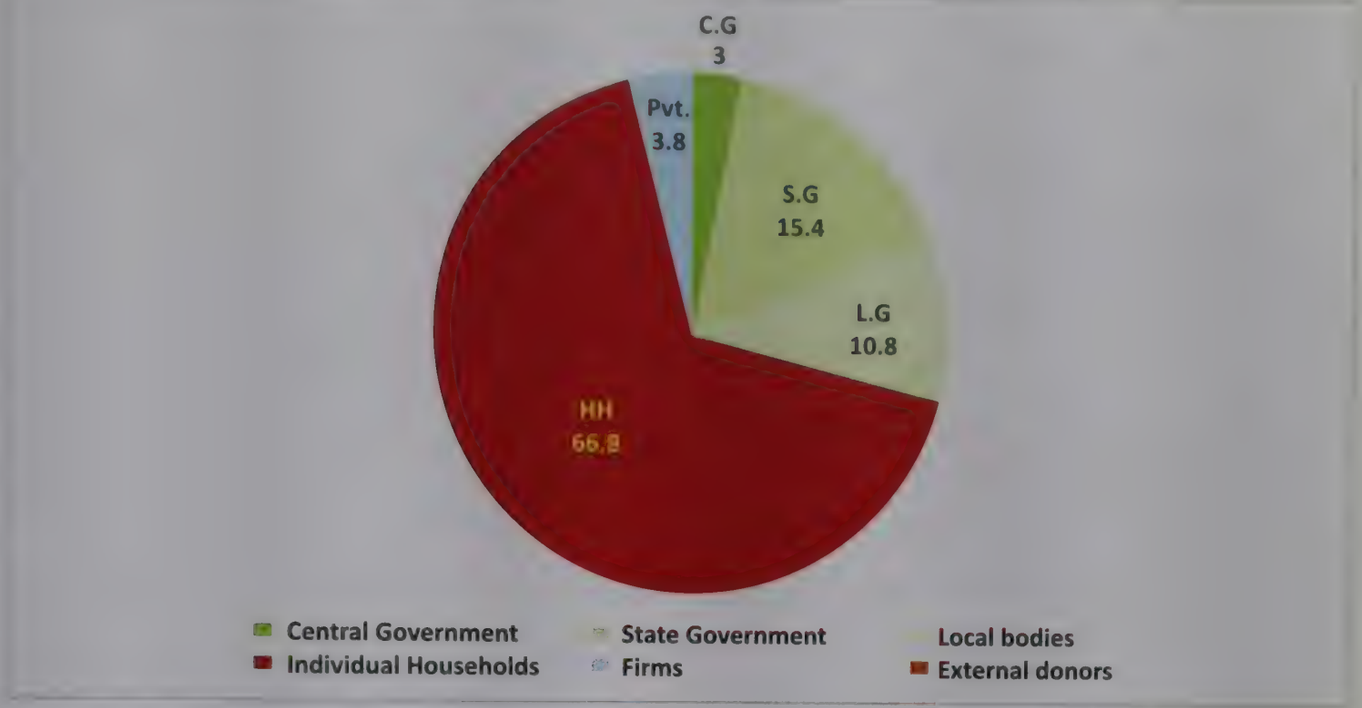
## Status of health financing in Karnataka

The situation in Karnataka is no better. State health accounts for the period 2004-05 indicate that the total health expenditure in Karnataka is about 37 billion rupees. Of this, only 28% is spent by the government. The governnment spending on health care was only Rs 197.35 per person per year.[3]

The government spent only 0.54% of the SDP in 2007-08 on health (Figure 3). The budgetary allocation for health care has also been reducing over time. At the turn of the millennium, the government of Karnataka allocated more than 5% of the total budget for health care. On the other hand, a decade later, this has reduced to 3.8%. If one disaggregates these figures by plan and non-plan expenditures, then one notices that the plan allocations have reduced from 8.1% (2001-02) to 4.9% (2009-10) while the non-plan allocations have also reduced from 4.4% to 3.3%. These figures show a decreasing commitment of the State as a whole to spend on health care.

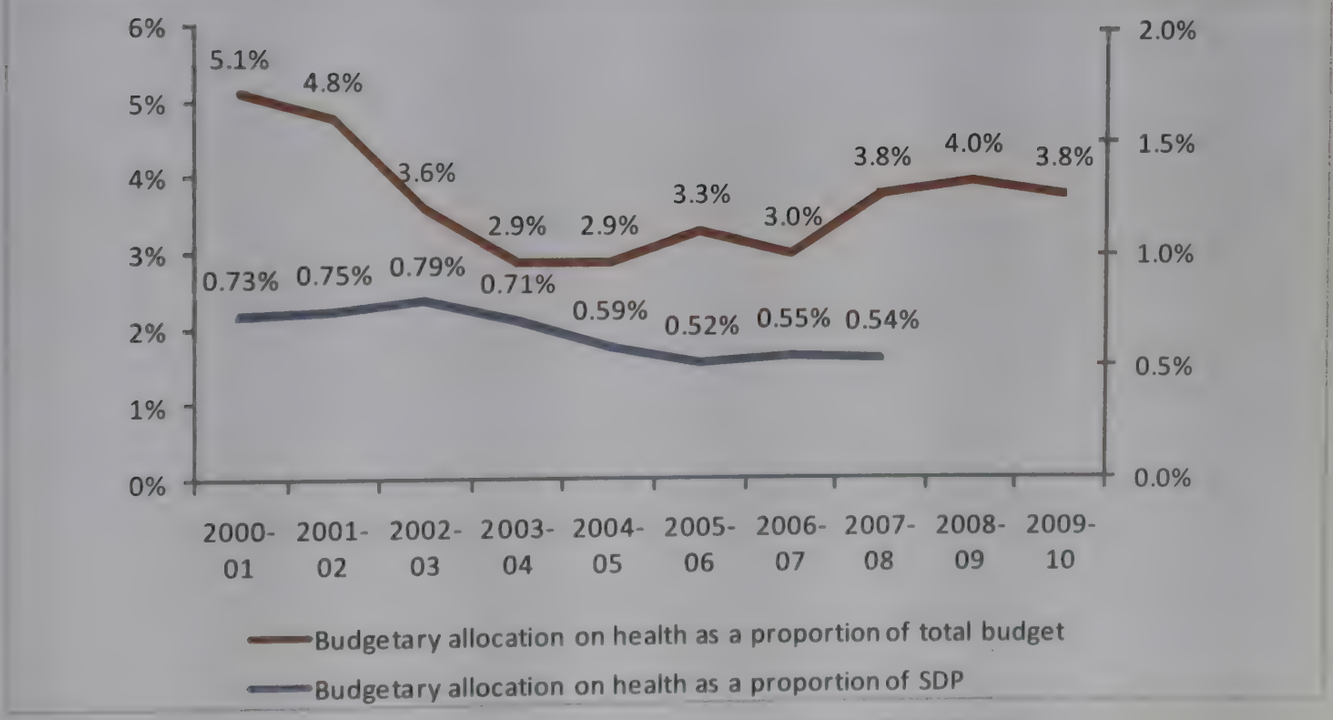
[3] Annigiri V. State Health Accounts: Karnataka. Journal of Health Management: 12; 327 – 372. 2010.

**Figure 2: Proportion of Total Health Expenditure by sources: Karnataka (2004-05)**




Source: State Health Accounts: Karnataka

**Figure 3: Health budgetary allocation as a proportion of the budget / SDP**




Source: Program budget analysis Anaka Aiyer, CBPS (2009)

In 2004-05, of the total government expenditure, about 26% was spent oncurative care, 28% on preventive care and 4% of education and training. Of this, only 8% was spent at the primary level, while the secondary and tertiary levels received 11 and 19% respectively. On the other hand, individual households spent 85% of their medical expenses on curative care and mostly at the secondary and tertiary level (21% and 10% respectively). A considerable proportion of all private health expenditure (62%) was spent on medicines and consumables.

Yet another barrier to using the government health services is the 'user fees' that are being charged to non-BPL patients. While often these are just token amounts, yet, for some it can be a veritable barrier to accessing health care. Unfortunately, data on this is not available. Data from two autonomous institutions show that user fees are a sizable proportion of their income (Table 1).

**Table 1: User fees in two autonomous institutions**

| | Sri Jayadeva Institute of Cardiovascular Sciences and Research | | Kidwai Memorial Institute of Oncology | |
|---|---|---|---|---|
| | Total income (in crores) | Proportion from user fees | Total income (in crores) | Proportion from user fees |
| 2003-04 | 28 | 67% | 17 | 40% |
| 2004-05 | 41 | 53% | 21 | 48% |
| 2005-06 | 43 | 77% | 22 | 35% |
| 2006-07 | 50 | 77% | 26 | 37% |
| 2007-08 | 58 | 74% | 29 | 38% |
| 2008-09 | 76 | 77% | | |
| TOTAL | 296 | 72% | 115 | 39% |

Source: Karnataka Knowledge Commission, 2009

These figures show that a sizable proportion of income for these institutions is from these user fees. In 2008, a total of 19,500 patients were admitted at Jayadeva. Assuming that all these fees came from inpatients, it implies that the average fee charged per inpatient is about Rs 30,000. However, detailed studies on this needs to be done to document the exact out-of-pocket payments made by the patients even in these government institutions.

All this means that the patient has to pay out-of-pocket (OOP) at the time of illness. The NSSO 60th round indicates that in rural areas, 22% of patients with minor ailments did not seek health care due to various reasons. And of the 78% who sought care, two thirds did so in the private sector and spent an average of Rs. 271 per episode of ailment. Similarly, 60% of admissions in the rural areas occurred in the private sector and the household had to spend Rs. 7918 per admission. Unfortunately, even in the government hospitals, the patient had to pay an average of Rs. 2,610 per admission. The latter is mostly due to the ser fees and also the medicines that need to be purchased from private pharmacies.

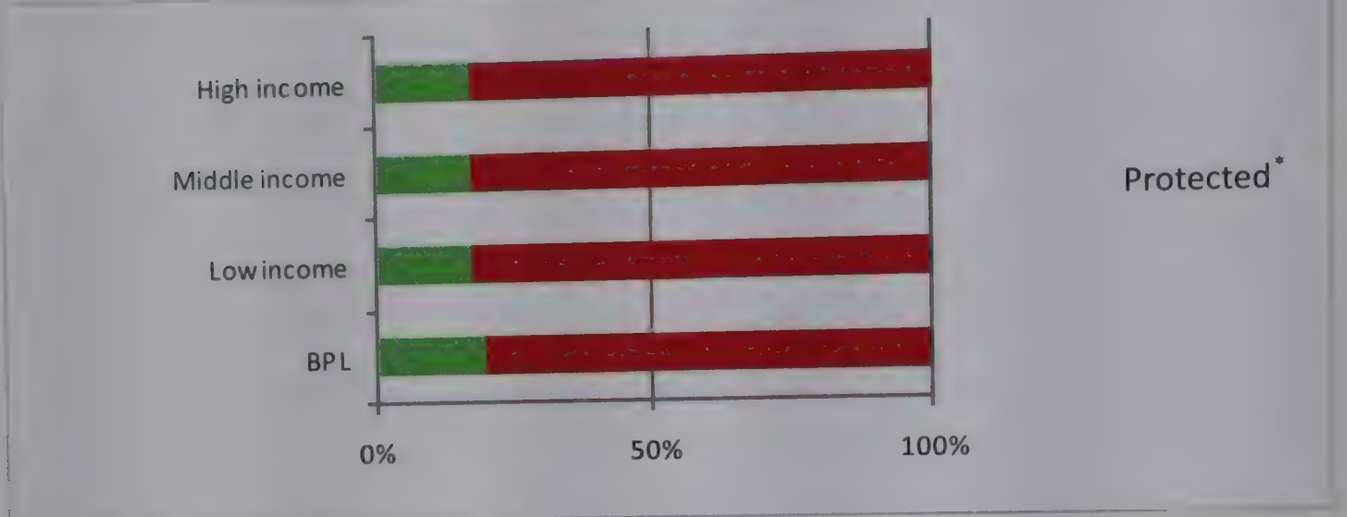
Such OOP has the danger of pushing families into indebtedness and poverty. To provide financial protection, the government has introduced various demand side financing schemes. The government's department of cooperatives supports the Yeshasvini Co-operative Farmers' Health Scheme, managed by the Yeshasvini trust. Recently, the department of labour has launched the RSBY in five districts, covering BPL families against common hospitalisation expenses. A new health insurance scheme called the Vajpayee Aarogya Suraksha (VAS) protects BPL families residing in "C category" districts of Karnataka against tertiary care hospitalisation expenses.

PH-100
12727 P10

## Issues in health financing in Karnataka

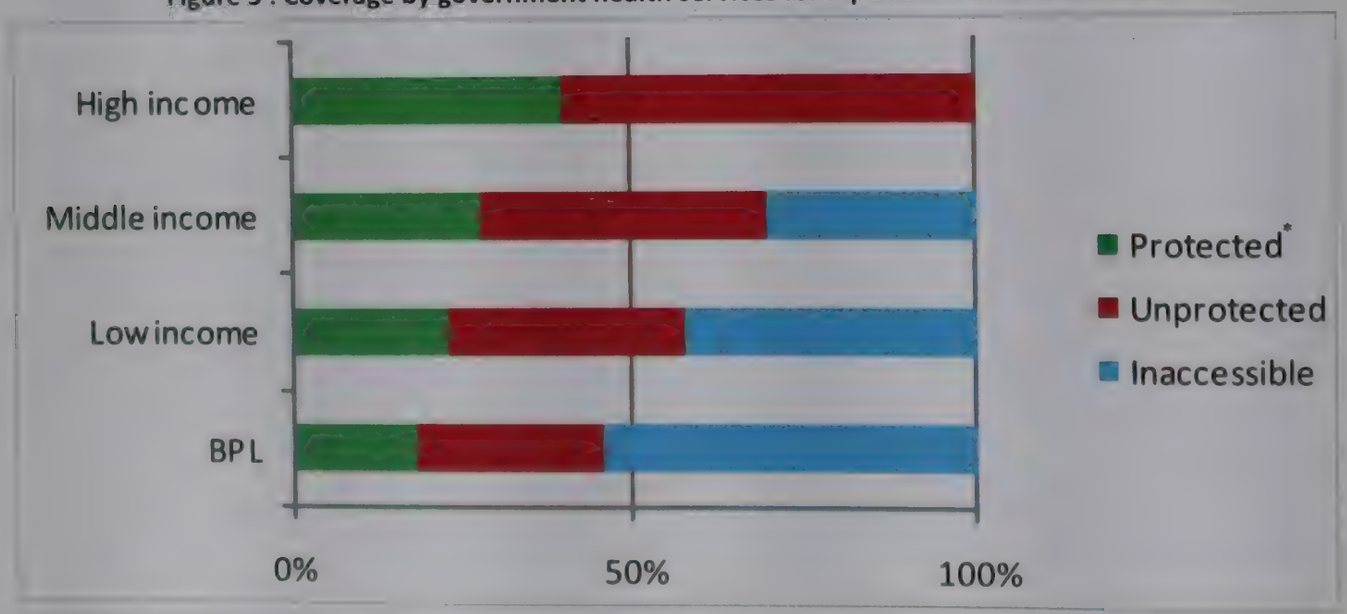
In spite of the government financing and the health insurance schemes, there is a gap in the coverage of the population. This is shown in Figures 4 & 5.

**Figure 4 : Coverage by government health services for outpatient care in Karnataka**




* Protected = those who use the government services and so theoretically do not have to pay for their health care.

**Figure 5 : Coverage by government health services for inpatient care in Karnataka [4]**




* Protected = those who use the government services and so theoretically do not have to pay for their health care.

[4] The assumption here is that the hospitalization rate for the high income group is the required hospitalization rate. The other income groups have a lower hospitalization rate, probably because of the problem of accessibility (In blue color).

With the introduction of the Yeshasvini, the proportion of patients who are accessing surgical services, especially among the low and middle income groups will increase. But this impact will be small, as surgical conditions are an insignificant part of all hospitalisations. On the other hand, with the introduction of the RSBY, one can expect an increase in access to hospital care among the BPL families. The VAS will have an insignificant effect on the overall situation of access to hospital care for the poor.

- **Key recommendations for the future course:**

  - Increase the overall budgetary allocation to the health sector. This increase could be from the current 4% of total budget to at least the previous 5%. In the medium term, this should be increased to at least 7% of the budget. One possible source of extra funds could be the 'sin tax' i.e., allocates the taxes received from sale of tobacco products exclusively for health care.

  - Urban health in big towns and cities should be the responsibility of the local Municipalities and Corporations. They should develop a system of urban primary health centres linked with referral centres. Budget should be allocated specifically for this.

  - This increased allocation should be focussed on enhanced supply of medicines to the government facilities. Increased salaries for the doctors and health staff should be another option. These measures would help in attracting patients

to the government facilities, since they would be able to get both a consultation and medicines free of charge. Additional funds should also be used to build infrastructure, especially sub-centres and quarters for nurses and doctors.

- Create a state body comprising of government officials, academicians, physicians, insurance company representatives and NGO activists that will be the nodal agency for all insurance schemes. This nodal agency will then develop a policy on health insurance for the state that will incorporate the needs of its citizens rather than the needs of separate donors / ministries

  a. This nodal agency will then coordinate with the various organisations / ministries / donors to develop an universal health insurance scheme forthe citizens of Karnataka that will meet the needs of all and cover the gaps in the current coverage.

  b. Ideally, the government should expand the existing RSBY and VAS combination to all districts, initially to cover the BPL families, but also to include the non-BPL families in a phased manner. The ultimate goal should be to provide universal access to health care for all, especially the vulnerable groups like BPL populations, SC / ST and minority households.

- The current system of user fees (or token fees) at the secondary level may be continued, as this is a significant source of

revenue for these facilities. However, the high user fees at tertiary level institutions, especially the autonomous ones should be stopped with immediate effect. The government should take the responsibility of financing the services provided by these hospitals, so that access is improved and even the poor can avail of the services.

- Introduce a system of rigorous analysis of outcome of budget expended and establish accountability for slippages in results targeted. The Performance Management System under Human Resource to focus on the outcomes vis-à-vis the resources allocated at all levels based on accurate and consistent measurement of progress and also bench marked against best practices.

Public-Private Partnership or PPP in the context of the health sector is an instrument for improving the health of the population. PPP is to be seen in the context of viewing the whole health sector as a national asset with health promotion as goal of all health providers, private or public. PPP is defined as a **collaborative effort and reciprocal relationship between two parties with clear terms and conditions, well-defined partnership structures, and specified performance indicators for delivering a set of health services within a stipulated period of time. They achieve mutually understood and agreed objectives by following certain mechanisms.**[5]

PPPs are becoming increasingly popular in the Indian context, mainly because of a multitude of reasons. These range from a failure of the government to deliver services, to a search for efficiency in service delivery, to donor pressure.

Traditionally, in a PPP model, the partners are the Public sector and the Private sector (for-profit private sector or not-for-profit private sector). Ideally, a PPP should be a win-win situation for both partners. The public sector expects better programme performance, enhanced quality, cost effectiveness and increased accessibility for the vulnerable from a PPP. On the other hand, the private sector expects to make a reasonable profit, expand its interests or fulfill its objectives of serving the vulnerable. Some of the potential benefits of a PPP are:

[5] Venkat Raman A, Bjorkman JW. Public-Private partnerships in health care in India. Routledge, London. 2009.

- A better quality of service for the beneficiary
- More choice to the community
- Cost reduction because of more efficiency
- This cost that is saved can be used to strengthen health services elsewhere
- Less duplication and wastage of resources
- Augmentation of resources and infrastructure
- Managerial and systemic improvements
- A good way of regulating the private sector in our country.

However, to make this happen, certain conditions need to be fulfilled:

- PPP should be a genuine partnership, with both entities viewing the other as an equal.
- The PPP should be developed based on local needs and a good situational analysis.
- There should be a reasonably vibrant private sector available in the region.
- The government should have the capacity to oversee the activities, enforcing performance standards and protect the interests of the community.

- The guidelines and contractual agreements should clearly spell out the roles and responsibilities of each of the partners.

Some of the disadvantages of a PPP model are:

- The private sector is unregulated by the public sector and so the former either underperforms or overcharges. The beneficiary does not get what he/she is entitled to.
- The private sector is not accountable to the local community. Hence community representatives lose their control over the health services and redressal mechanisms are limited.
- PPP may be a subtle mechanism of privatizing the health services. So it is important to ensure that the ownership and oversight function remains with the public sector.
- Partners do not realize the complexity of a PPP. The government sees it more from a managerial perspective, while it needs to be seen also from an ideological perspective. There could be conflicting interests, with the public sector interested in improving the services, while the for-profit private sector may be interested in profits. Unless this dichotomy is recognized and addressed, PPPs can fail.

Some key steps to initiate a PPP are listed below:

- Mapping of private sector in the region to ensure that there is adequate quantity.
- Accreditation of the private sector to ensure adequate quality and standards.

- Purchasing services – this is a skill that needs to be developed.
- Legalizing the PPP through a contract between the partners.
- Monitoring the PPP to ensure that the promised services are delivered.

Under the Tenth Five Year Plan (2002-2007), initiatives have been taken to define the role of the government, private and voluntary organizations in meeting the growing needs for health care services including RCH and other national health programmers. The Mid Term Appraisal of the Tenth Five Year Plan also advocates for partnerships subject to suitability at the primary, secondary and tertiary levels.

Under the Reproductive and Child Health Programme Phase II (2005-2009), several initiatives have been proposed to strengthen social-franchising initiatives. National Rural Health Mission (NRHM 2005-2012) recently launched by the Hon'ble Prime Minister of India also proposes to support the development and effective implementation of regulating mechanism for the private health sector to ensure equity, transparency and accountability in achieving the public health goals.

The Private and Non-profit sectors are also very much accountable to overall health systems and services of the country. Therefore, synergies where all the stakeholders feel they are part of the system and do everything possible to strengthen national policies and programmes needs to be emphasized with a proactive role from the Government.

## Are PPPs effective?

Evidence on the effectiveness of PPPs currently being implemented in Karnataka has not been systematically gathered. Well designed empirical studies are needed to evaluate the relative effectiveness of the different models under implementation. It is imperative that the government reviews the existing PPP programmes and captures the lessons that need to be learnt. This will help when designing future PPP.

**Recommendations:**

1. Review the existing and established PPPs using robust study designs and external agencies to document whether the PPP has achieved its objectives. It is also required to document why it worked or did not work and what can be done to improve the outcomes.

2. Create a PPP cell in the Department and build its capacity to develop and monitor partnerships.

3. The department needs to be aware of its roles and responsibilities and should not mistake PPP for privatisation.

**Some examples of PPP in Karnataka are:**

| Name of the partnership | Public partner | Private partner | Services provided | Type of PPP |
|---|---|---|---|---|
| Handing over of PHC | Dept. of HFW | Karuna Trust (not-for-profit) | Management of PHCs | Contracting out |
| Handing over of Rajiv Gandhi Superspeciality Hospital (Raichur) | Dept. of HFW | Apollo Hospital Enterprises Ltd. (for profit) | Management of the Rajiv Gandhi Superspeciality hospital in Raichur | Contracting out |
| Karnataka Integrated Telemedicine project | Dept. of HFW + ISRO | Narayana Hrudayalaya (for profit) | Providing telemedicine services (cardiology) for patients in Chamarajnagar district | Joint venture |
| Yeshasvini Health Insurance | Dept. of Cooperatives | Yeshasvini Trust (not-for-profit) | Health insurance cover against surgical expenses | Health insurance |
| Vajpayee Aarogya Suraksha | Dept. of HFW | Private hospitals (for profit) | Health insurance cover against tertiary care expenses | Health insurance |
| Rashtriya Swasthya Bima Yojana | Dept. of Labour | Private hospitals (for profit) | Health insurance cover against secondary hospitalization expenses | Health insurance |
| 108 ambulance services | Dept. of HFW | EMRI (for profit) | Emergency transport of patients | Contracting in |
| Citizen's Help Desk | Dept. of HFW | NGOs (not-for-profit) | Reception desk at district hospitals | Contracting in |
| Mobile clinics | Dept. of HFW | NGOs (not-for-profit) | Outreach services to remote areas | Contracting in |
| Jayadeva Heart Hospital | Dept. of HFW | Jayadeva Hospital (not-for-profit) | Increased autonomy to plan and implement services | Autonomy |

## ANNEXURE

## MODELS OF PUBLIC PRIVATE PARTNERSHIPS

Various models can be utilized for putting these partnerships into action; some of the possible mechanisms for implementation of PPP are given below:

1. **Franchising :** Franchise is a type of business model whereby a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner in a certain place over a specified period. Typically the franchiser has developed specialized skills, knowledge, and strategies and thus able to share its blueprint for a successful product line with franchisees. The franchisees contribute resources of their own to set up a clinic and pay membership to franchiser.

   **Partial Franchising :** Most of the social franchising models followed in India are partial franchising models. Franchiser identifies private hospitals and enters into an agreement with franchisee to provide certain services in lieu of payment of fee or commissions from sale of services and goods. These contracts largely confine to a basket of RCH services. However franchisee provides many other services that are not part of the contract. There is no control over quality of services provided by franchisee outside the contract. Usually one-year subscription fee is given by franchisee to franchiser. In this arrangement, increased performance of franchisee does

not lead to increased revenues to franchiser. There is no incentive to franchiser to improve performance through promotional activities. One way to overcome this problem is to have a revenue sharing arrangement between franchiser and franchisee. However many of the hospitals are not transparent about their financial transactions or do they maintain complete record of services provided. One of the innovative aspects of these social franchising efforts is to link rural medical practitioners and/or community based organizations such as SHG to franchisee that has helped to increase the client load for RCH services. The partial franchising efforts in India do not represent public-private partnerships but offer a model and experiences that are highly relevant. Government can have its own model of social franchising with franchiser-franchisee-RMP-CBO linkages. Concentration of private hospitals/ nursing homes in urban areas has to be taken into consideration. In many rural and inaccessible areas where the need for improved access to services is the highest, there are not private hospitals/nursing homes.

**Full Franchising :** Franchisee provides services defined by the franchiser and expansion of range of services depends on mutual agreement. For existing nursing homes and hospitals, this can mean a considerable revenue loss and this has to be filled in by subsidies till the client load improves and the hospitals start making operating profits. Time required for transition of loss making unit to profit making unit depends on a variety of factors such as location of hospitals, demand for services, perceived quality of services and competition. Not many hospitals may opt for this given

the uncertainties in financial returns, unless guarantees are given to sustain the model for a long period of time.

**2. Branded Clinics**

A few organizations have started a chain of branded clinics that offer a wide range of reproductive and child health services. There is scope to expand the range of services provided by these clinics and add social mobilization efforts to their functions. These branded clinics can be opened in areas where there is a need with minimum effort. Branded clinics are more sustainable because of their ability to generate more income than social franchising units.

**3. Contracting Out**

Contracting out refers to a situation in which private providers receive a budget to provide certain services and manage a government health unit. The two parties usually agree on some or all of the following: the quantity and the quality and the duration of the contract.

Common criteria for identifying those government health clinics that need to be contracted out are the first step in this direction. Large number of vacancies for a long period, high absenteeism, and consistent low performance on all RCH indicators could be the critical criteria. Some states are more prepared for contracting out services compared to others. Fear of losing jobs and perceived shrinking role of government in health sector are the main reasons for resistance. Advocacy efforts are required in

those states where resistance levels are high for contracting out services.

There are several levels at which the contracting out can be done depending on the degrees of freedom given to the contractor. Higher the freedom, higher should be the performance levels of key RCH indicators.

**Option 1** : Government hands over the physical infrastructure, equipment, budget and personnel of a health unit to the selected agency.

**Option 2** : Government hands over the physical infrastructure, equipment, budget but gives freedom to the selected agency to recruit personnel as per their terms and conditions but following the government norms such as one ANM per 5,000/3,000 population.

**Option 3** : Government hands over the physical infrastructure, equipment, and budget but gives freedom the select agency to have their own service delivery models without following the fixed prescribed pattern.

**Option 4** : Government hands over the physical infrastructure, equipment, budget and gives freedom to the select agency to have their own personnel, service delivery models, freedom to expand types of services provided and freedom to introduce user fee and recover some proportion of costs.

## 4. Contracting In

Contracting in is done for a variety of services particularly in major hospitals. These include: maintenance of buildings, utilities, housekeeping, meals, medicine stores, diagnostic facilities, transport, security, communications etc. Hospitals are given freedom to choose the services to be given to contractors. Often they lack comprehensive plans and sound financial analysis.

Nevertheless, contracting in many hospitals has resulted in conservation of resources, improved efficiency and better quality of services. Contracting in services leads to surplus human resources and hey need to be transferred to other health units to fill in vacant positions, if any. Resentment of employees and interference of trade unions are some of the major obstacles to this process.

Contracting in does not work in some places for particular types of services. For instance some state governments could not attract private sector participation for diagnostic services in remote area hospitals with low client load. One option is to subsidize the equipment purchased by private agencies and the other is to make services located in government hospitals open to all. Even a person with prescription from private clinic should be allowed to use privately run diagnostic facilities in government hospitals. This increases the volume of transactions and makes the unit financially viable.

Recruiting doctors, technicians and other staff on contractual basis for a stipulated period of time is widely practiced in several states. In some cases the contracted staff performs all duties of regular staff and in other instances; their services are contracted for a few days in a month and to provide services in a particular clinic. In many states, a large proportion of vacant positions were filled in following this process.

## 5. Social Marketing

One of the earliest efforts at building public-private partnerships is in the area of social marketing of contraceptives. For more than a decade, HLL, ITC, Indian Oil and other large FMCG companies helped the government with social marketing of contraceptives by piggy backing Nirodh to their products. Later private social marketing companies have emerged as a force to reckon with and gained considerable experience in marketing contraceptive products both social and commercial. The increasing trend now is to enlarge the basket of products by including ORS, IFA tablets, and other health products to make the marketing efforts more self-sustaining. Government provides the subsidized contraceptives, and finances brand and point of purchase promotion schemes of selected marketing agencies.

## 6. Build, Operate and Transfer

Build, operate and transfer (BOT) models are highly successful in infrastructure development sector in India. BOT requires part financing of projects by the government, financial guarantees

when needed, subsidized land at prime locations and assurance of reasonable returns on investment. These models could be useful to establish large hospitals and ensure quality services at reasonable rates to poor people. However these hospitals should be able to withstand market competition to survive and sustain them.

### 7. Joint Venture Companies

Joint venture companies are companies launched with equity participation of government and private sector. Proportion of equity of each partner may vary from one venture to another. Joint venture companies, in most cases in commercial sector, have not succeeded in India due to lack of understanding and trust between partners, inordinate delays in decision-making and dominance of government even with low equity. There is even less chance of their succeeding in health sector.

### 8. Voucher System

A voucher is a document that can be exchanged for defined goods or services as a token of payment (tied-cash"). This consists of designing, developing and valuing health packages for various common ailments / conditions (like ANC package / STI package / Teen pregnancy package / family planning package etc) which can be bought by the people at specific intervals of time. These vouchers can then be redeemed for receiving a set of services (like 1-2 consultations, lab tests, procedures, counseling and drugs for the condition) from certified / accredited hospitals or clinics and

are to be used within 2-3 months of buying the voucher. This means that the package can be bought, used as and when required and ensures privacy for the client.

Regular monitoring is required for ensuring quality standards, training of providers and networking with the people to ensure that the proper use of vouchers. The vouchers are redeemed to the clinics for the number utilised depending on the price for each package of service provided.

Clinics that fail the quality standards of service and do not do well on patient satisfaction can be removed from the certified services.

## 9. Donations from individuals

Within a large country like India and with a creditable high income and middle income groups there are many examples of private donors willing to partner with the public sector. Rich philanthropists, individual donations may be the crucial requirement in areas to make the PPP initiative effective in delivering health care. Though in some states mechanisms and provisions are present for utilising these private donations for improving local health situation, many other states lack these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations to contribute to the growth and improvement in reproductive and child health services in their area.

## 10. Partnerships with Social Clubs and Groups (e.g. Rotary Club)

Clubs like Rotary and Lion's played a significant role in immunization campaigns, Pulse Polio campaign and other health care services. Since these clubs have a nationwide network, their involvement ensures better coverage. They also bring in their expertise and resources to the health care services.

## 11. Involvement of Corporate sector

The corporate sector has a rich history of being supportive of the health and family welfare interventions for people that work in and live around its premises. Under Corporate Social Responsibility, the corporate sector through the Confederation of Indian Industries (CII) and the Federation of Indian Chamber of Commerce and Industries (FICCI) and several other sector wise business and industry associations have played a significant role in advocacy efforts, funding non-government organizations for innovative interventions, introducing new schemes to encourage service utilization and expending their own resources for promotion of reproductive and child health services particularly family planning services.

## 12. Partnership with Professional Associations

There are several professional associations such as Indian Medical Association, Gynaecologists federation, nurses associations etc. These association from time to tome extended help in launching new programmes such as Vande Mataram Scheme, Gaon Chalo project and immunization programme particularly pulse polio.

They have technical skills and expertise to provide advice on various other matters such as setting standard protocols, quality assurance systems and accreditation. However the managerial capacities of these professional associations have to be strengthened. Moreover, with widespread chapters / branches all over the country and huge membership they can play a very important on ethical issues.

## 13. Capacity building of private providers, pharmacists and informal providers (RMPs)

Several initiatives taken by the government in the past to improve the technical and counseling skills of private medical practitioners' particularly rural medical practitioners by improved quality of services offered by them. Since they have a huge presence in rural areas and urban slums and a significant proportion of population depend on them for services, there is a need to involve them in a significant way to create demand for services and in making referral system effective. Similarly government medical officers and administrator benefited by participating in training programmes conducted by private institutions. Consultancy services offered by private institutions in the areas of communications, systems development etc is another example of public-private partnership. Another area of partnership is contracting out management of training institutions such as ANM Training Centres, Regional Training Centres to NGOs and private agencies.

PH-100 P10
12727

## 14. Special "Category Campaigns" with the private sector to improve health

The WHO-ORS campaign and the Goli- ke- Hamjoli campaigns are examples of the use of the commercial sector to advance national health goals. The category campaigns expand use of a health/family-planning product, increases the volume and the users for the product. In India, the Goli ke Hamjoli and WHO-ORS campaigns succeeded in increasing product awareness, availability, sales, and use. At the same time, this entails using a generic promotional strategy, increased private-sector investment and the value of the market, policy change; coordination with partner pharmaceutical firms; affiliation with professional associations; expansion of market channels; and consumer outreach. Initially, the program should use mass media vehicles to improve product awareness and contemplation. But, as the program develops, its emphasis should shift to encouraging product trial, and use interpersonal approaches to reach out to potential consumers.

## 15. Autonomous Institutions

Giving autonomy to public institutions within the system can lead to improvement in quality, accountability and efficiency. It also ensures greater involvement and ownership at the level of the institution, ensuring greater morale and encouragement to the work-force. Many such projects have been implemented and have shown to yield excellent results, as the need for the change in management systems is self-driven. This is also sustainable and easy to replicate.

## 16. Partnering with CBOs / NGOs

For designing and implementing innovative approaches to RCH services, partnerships with community based organizations and non-government organizations are a significant step. Government for long encouraged participation these grass roots organizations in demand creation and delivery of services. These organizations often worked in remote rural areas where access to RCH services is difficult. Recent NGO Policy of the MOHFW envisages a scheme where each district would have a mother NGO and linked to several field NGOs within the district with greater degree of autonomy and decentralization. Community mobilization efforts yield effective results and community ownership of the programme is sustainable.

## 17. Mobile Health Vans

In geographical areas with difficult terrain with no transport facilities and poor road connectivity usually the outreach and institutional services of PHCs are not to the expected standards. This has resulted in gross under utilization of services. To overcome this problem, in some states private sector agencies have taken a lead in launching mobile vans. These vans go to clearly identified central points on fixed days and provide comprehensive health services including RCH services to a cluster of villages. While private sector resources were put to use to purchase vans, the government contributed to these services by deputing medical officers and medicines. This approach has significantly helped improve access to quality services.

## 18. Insurance and Public-Private Partnerships

In one of the recently planned schemes, the government insures and pays health insurance premium for families below poverty line. These families in turn are insured against expenses on health and hospitalisation, up to a certain amount. On similar principle, it is possible to develop sustainable health insurance schemes that are community based. In such schemes, the community members pay a minimum insurance premium per month and get insured against certain level of health expenditure. This protects them from sudden and unexpected expenditure on health. Such community based schemes also ensure that the local needs and expectations of the people are met, by preferentially reimbursing local trained healthcare providers.

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